Exhibit D

STEPHEN B. LEVINE, M.D.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

Civil Action No. 07-12325-DPW

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KATHEENA NEVIA SONEEYA,

f/k/a Kenneth Hunt,

Plaintiff,

V.

THOMAS A. TURCO III,

in his official capacity as

Commissioner of the Massachusetts

Department of Corrections,

Defendant.

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DEPOSITION OF STEPHEN B. LEVINE, M.D.

Thursday, August 30th, 2018, 9:42 a.m.

Regus

2000 Auburn Drive, Beachwood, OH 44122

Reported by:

Jill A. Kulewsky, RPR

JOB NO. 146861

answer to it. I think the verbiage of the criteria may have changed in very subtle ways, but practically speaking, it did not.

The name change came about, in part, because one can be gender dysphoric without having a disorder. So there are many people who objected to the D in GID. The assumption that this variation in identity was a disorder was politically objectionable to many people in the trans community and those people who advocate for those -- for those what used to be patients.

So this is probably going to change again, and if we had this deposition in two years, we would probably call this not gender dysphoria but gender incongruence.

Q. Could you tell me a little bit more about that, why you think it's changing, what's changing about it?

A. This is fraught -- this is a political subject. The psychiatric

conditions, what constitutes a disorder changes with the time, and afterall, the DSM changes every 10, 12 years.

We in psychiatry and mental health, we reconfigure our concepts about every decade about what is a disorder and how to name them, and both scientific data, clinical experience and politics all influence the DSM.

And the DSM is in controversy with the World Health Organization that produces the ICD, the International Classification of Diseases. So the proposed ICD-11 is to stop calling this a disorder, stop implying by nosology that there is anything wrong with these people, and that this is just going to be considered a phenomenon that affects one's mental health.

So that's why there are people who are advocating to get rid of gender dysphoria and just call it gender incongruence because some people have gender incongruence who are not

dysphoric, they just accept the fact that they have the body of one -- an anatomic body and mental identity that is somewhat different from their body, and at various times in their life they struggle with that incongruence, but they're not mentally distressed, and therefore, they don't have a disorder or they're not dysphoric.

So when you see in the development of one's gender sense, for in the population there are enormous variations in the degree to which one is consonant or happy with or feels masculine in a male body, where to draw a line between disorder, disease, mental condition, emotional distress and just ordinary human diversity is unclear.

And the changes in nosology are reflecting the increased awareness over time, both within the trans community and the mental health community, of great diversity and the lack of invariability of distress over

the diversity or over the incongruence. So you and I are caught up at a certain point in time where our concepts are rapidly changing, and none of us are very sure what's going on.

It's not like schizophrenia. It's not like somebody who's tried to jump off a bridge six times in his or her life.

Q. So would you --

A. Okay.

Q. Is GD a medical or psychiatric condition, in your opinion?

A. In my opinion, it is definitely a psychiatric condition.

Q. Are you familiar with WPATH?

A. Oh, yes.

Q. What is it?

A. Well, it used to be the Harry Benjamin International Gender Dysphoria Association. I, in fact, was the chairman in writing the standards of care for the 19 -- the 5th version. It was published in 1999. Most of the

language -- as I read the seventh version, much of the language I actually wrote.

And the seventh version is just lifted from the fifth version, so I'm sort of familiar with it.

Q. We'll get to the standards in just a second. What's your understanding of what that organization does?

A. That organization initially arose to study the phenomenon of men who wanted to live as women and women who wanted to live as men. It was -- it began in the '70s -- in the '60s, actually, late '60s, I think, and it was funded by somebody who himself was a transgendered person, and we began developing -- I joined it in the '70s, and we began to articulate the standards of care for how these people ought to be handled by psychiatry, by endocrinology and by surgery.

So it began as a bunch of academics interested in this subject, and

it became over the years not just an academic institution, but it became -- well, an organization that invited the trans people themselves to be part of it.

By doing that, the organization became an advocate of trans people, and it always claims to be a scientific organization, but in fact, there is a great distinction between science and behavior that science dictates for professionals and advocacy, which leads to entirely different things far beyond science.

So what kind of organization is this today, I think you're asking me? Well, it's a mixture -- it's a minority rights organization that feels very strongly that there's nothing inherently wrong with anybody who has an incongruence in their gender identity, and it's not a symptom of anything, it's just the way people are, and that these people are marginalized and discriminated against just like homosexual people used

to be by psychiatry in the mid '70s, and that anyone who is interested in trans people needed to be their strong advocate at all times.

So that became a standard of -- I would say if you're a credentialed person, if you know about this, you must be an advocate. If you're a cynic, if you're a scientific, if you have skepticism, well, you may be the enemy.

So what has happened is that over the years, WPATH has become an advocacy organization that lawyers or the legal profession, in trying to understand how medicine operates, relies very heavily on the collective wisdom of organizations.

So WPATH has great respect in the courtroom and great respect as the international standard for how people ought to be treated, even though there are parts of WPATH that say these are case-by-case decisions, and that patients

elect surgeries, doctors don't recommend surgeries.

It seems that the WPATH standards have stimulated a social phenomenon in this society, and not just in America but elsewhere, where if a person wants something, the doctors should be providing them. If a doctor is skeptical about providing what this teenager or 70-year-old person wants, then the doctor is obviously not competent.

As a result of that, there are many people who just abandon interest in these patients because they just feel like WPATH is much more political than it is scientific, and the doctors need to be skeptical and need to be humble, and there's too much certainty embodied in the behavior that, I would say, rests upon the standards of care.

The standards of care are actually more conservative sounding than the people who quote them are, and so